LOS ANGELES COUNTY COMMISSION ON HIV

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PLANNING, PRIORITIES & ALLOCATIONS (PP&A) COMMITTEE MEETING MINUTES

March 17, 2015

PP&A MEMBERS PRESENT	PP&A MEMBERS ABSENT	PUBLIC	COMM STAFF/CONSULTANTS
Al Ballesteros, MBA, *Co-Chair*	Michelle Enfield	Tangerine Bingham	Carolyn Echols-Watson, MPA
Brad Land, *Co-Chair*	Miguel Martinez, MPH, MSW	Miguel Fernandez	Jane Nachazel
Abad Lopez	Sabel Samone-Loreca/Susan Forrest	Suzette Flynn	Yeghishe Nazinyan, MS, MD
Marc McMillin	Monique Tula	Aaron Fox	
Mario Pérez, MPH		Miki Jackson	
Juan Rivera		John Palomo	**DHSP STAFF**
LaShonda Spencer, MD		Juan Preciado	Michael Green, MHSA, PhD
		Scott Singer	
		Jason Wise	

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1) **Agenda**: Planning, Priorities & Allocations (PP&A) Committee Meeting Agenda, *3/17/2015*
2) **Minutes**: Planning, Priorities & Allocations (PP&A) Committee Meeting Minutes, *8/28/2012*
3) **Minutes**: Planning, Priorities & Allocations (PP&A) Committee Meeting Minutes, *4/23/2013*
4) **Minutes**: Planning, Priorities & Allocations (PP&A) Committee Meeting Minutes, *5/28/2013*
5) **Minutes**: Planning, Priorities & Allocations (PP&A) Committee Meeting Minutes, *6/10/2013*
6) **Minutes**: Planning, Priorities & Allocations (PP&A) Committee Meeting Minutes, *1/20/2015*
7) **Minutes**: Planning, Priorities & Allocations (PP&A) Committee Meeting Minutes, *1/27/2015*
8) **Minutes**: Planning, Priorities & Allocations (PP&A) Committee Meeting Minutes, *2/17/2015*
9) **Report**: Utilization of AOM HIV Services in the City of Long Beach, *3/17/2015*
10) **PowerPoint**: My Health LA (MHLA), *3/17/2015*
11) **Report**: HIV Care Continuum: The Connection Between Housing and Improved Outcomes Along the HIV Care Continuum, *2014*
12) **Budget Request**: The National AIDS Housing Coalition: HOPWA 2012 Budget Request: NHCA Recommends $427 Million, *2012*
13) **Table**: PP&A Service/Intervention Recommendations, *9/22/2014*

1. **CALL TO ORDER**: Mr. Land called the meeting to order at 1:15 pm.

2. **APPROVAL OF AGENDA**:
   MOTION #1: Approve the Agenda Order **(*Passed by Consensus*)**.

3. **APPROVAL OF MEETING MINUTES**:
   MOTION #2: Approve minutes from the 8/28/2012, 4/23/2013, 5/28/2013, 6/10/2013, 1/20/2015, 1/27/2015 and 2/17/2015 Planning, Priorities and Allocations (PP&A) Committee meetings, as presented **(*Passed by Consensus*)**.

4. **PUBLIC COMMENT *(Non-Agendized or Follow-Up)***: There were no comments.

5. **COMMITTEE COMMENT *(Non-Agendized or Follow-Up)***: There were no comments.

6. **CO-CHAIRS' REPORT**:
   - Mr. Land noted a public comment at a prior meeting requested the City of Long Beach provide the same kind of information provided by DHSP on Ambulatory Outpatient Medical (AOM) services in the City. It had not done so before as information was similar and both draw on Casewatch data. Dr. Mitchell Kushner, Health Officer, City of Long Beach, Department of Health and Human Services has provided the requested response. As anticipated, information is similar to the DHSP report.
   - Both reports confirm access to Ryan White-funded AOM services in the City. The Standards and Best Practices (SBP) Committee also previously presented its literature review results on potential verifiable impact of patient choice. It found little literature on the subject due to difficulty in establishing verifiable data and made no patient choice recommendation.
   - Dr. Green added Emily Gantz McKay has been assisting the Commission in developing an unmet need plan which will seek to identify PLWH who have dropped out of care and re-engage them. HIPAA limits how surveillance data may be used, but California law requires reporting laboratory values in eHARS. DHSP uses the values as a proxy for being in medical care.
   - Mr. Land reported he and Ms. Tula are revising the PP&A Work Plan. More user friendly, it will incorporate prevention requirements such as the recently completed Annual Progress Report. The Priority- and Allocation-Setting (P-and-A) process will change from a one- to a two-year process with adjustments in the second year to free time to address prevention.
   - ➲ PP&A accepted the Utilization of AOM HIV Services in the City of Long Beach report from Dr. Kushner. It will be forwarded to the Executive Committee for consideration in its response to the 4th Supervisorial District's inquiry on the subject.
   - ➲ The revised Work Plan will likely be available for PP&A review in one or two months.

7. **MY HEALTH LA**:
   - Ms. Bingham, Director, Office of Managed Care, Department of Health Services (DHS), presented on My Health LA (MHLA). MHLA provides eligible uninsured County residents aged six or older with access to coordinated care via a medical home model. Those who lack access to a full-scope health program are also eligible. MHLA is not health insurance so enrollees remain uninsured, but receive care cost-free. Household income must be at or below 138% Federal Poverty Level.
   - MHLA uses One-e-App, a web-based eligibility and enrollment system. MHLA became operational 10/1/2014 and had enrolled 93,000 as of 2/28/2015 with 94% of enrollees Hispanic. Participants were enrolled individually and renew eligibility every 12 months. Enrollment is open and promoted on a continuous basis for the many eligible people not yet enrolled.
   - MHLA provides primary care, diagnostics, pharmacy, specialty, emergency, urgent care, hospitalization and behavioral health referrals. Dental care is not included, but enrollees whose clinics offer it may access it at their medical home. There are 54 community partner agencies with 183 sites for primary care, diagnostics and pharmacy.
   - DHS provides specialty, urgent care not provided by agencies, emergency and hospitalization services. MHLA refers to the Departments of Mental Health and, for substance abuse, Public Health as appropriate.
   - PLWH not in a full-scope program providing primary health care in an outpatient setting are eligible for MHLA. It does not collect health status or pre-existing condition information at enrollment and has no data on numbers of PLWH applicants. MHLA does require its clinics to provide encounter data so will develop chronic condition and health information over time.
   - The PowerPoint noted PLWH receiving Ryan White (RW) would not enroll in MHLA as they receive services through RW.
   - Mr. Pérez, Director, DHSP, pointed out, however, that RW does not cover hospitalization or non-HIV-related medical care, e.g., an orthopedist. DHSP does contract with AIDS Healthcare Foundation to facilitate referrals to CHAIN for HIV-related subspecialty services, but relies on DHS for most non-HIV-related services. Most RW providers have a line item to complement ADAP for non-HIV medications. Others refer to DHS or private pharmacies willing to donate some medications.
   - Ms. Bingham said DHS has a new system for non-MHLA participants who are uninsured to apply for specialty care. The new system is in addition to eConsult and designed to ensure services are provided in a more timely fashion.
   - ➲ Ms. Bingham will forward to staff the DHS document detailing the purpose of the new program for non-MHLA participants who are uninsured to apply for specialty care. It lists populations served, locations and includes the new application form.
   - ➲ Ms. Bingham will develop a RW-specific HIV slide, verify information with Mr. Pérez and then forward it to PP&A.

8. **ASSESSMENT OF HOUSING GAPS**:
   - Ms. Flynn, HOPWA, Department of Housing, City of Los Angeles, reported on HOPWA services. The National AIDS Housing Coalition used a 2012 Los Angeles unmet need estimate of over 8,000, but she questioned how it was derived considering Los Angeles' lack of affordable housing. She asked HUD how to calculate unmet need, but received no response.
   - Most seeking HOPWA assistance are at or below 30% of Area Median Income (AMI) which is less than $20,000 annual income for one person. Most such applicants are sharing housing, e.g., renting a room. HOPWA has a program that cuts off assistance if a client pays more than 70% of income in rent to facilitate moving toward more sustainable housing.

- HOPWA seeks affordable units for those who cannot afford housing after a year. Some are public housing. Others are units within building projects guaranteed affordable for 55 years. The biggest affordable unit challenge is lack of turnover.
- Housing Choice (previously Section 8) vouchers are offered through various Housing Authorities in the County. Clients pay 30% of income in rent for any market rate unit if the owner accepts vouchers. Shelter+Care vouchers are similar, but for those who are homeless, disabled and meet other requirements. Clients pay 30% of income and receive services.
- HOPWA regulations permit a broad range of housing and supportive services, e.g., the City has a unique program that provides vouchers for one year and then transitions clients to Housing Choice vouchers so long as they remain eligible.
- HOPWA also funds emergency and transitional housing which requires services to assist in moving into a permanent unit. One program pays for moving costs with basic HOPWA eligibility, HIV diagnosis and annual income no more than 80% AMI. Short-Term Rent, Mortgage or Utility is a subsidy for up to 26 weeks to help clients retain housing during a financial crisis.
- The Los Angeles 2014 HOPWA grant of $15.9 million was the largest to date, but still inadequate and considerably less than New York's grant of approximately $48 million. HOPWA allocated approximately $11 million to housing subsidies which cost approximately $1,000 per unit. The City also leverages funds with new projects, e.g., it contributed $2 million to the Gateways affordable housing project which has 20 units set aside for homeless PLWH. The grant also funds housing specialists, an online housing information resource center, residential services coordination and some supportive services.
- HOPWA was redesigned and an RFP released mid-February. Agencies were reduced from 38 to 28 to reduce administrative burden and emphasize regional offices to ensure all services are available countywide. HOPWA is partnering with DHSP to maximize resources with resultant savings going to housing. Housing staff will also eventually co-locate in medical homes.
- DHS has initiated Housing for Health to facilitate housing for homeless persons who are high-utilizers of County medical services. The initial $18 million allocation provides rental housing assistance and supportive services. HOPWA has located a staff person at the Rand Schrader Clinic to assist in coordinating PLWH services.
- Working with DHSP and DHS is consistent with the federal emphasis on better housing coordination to support health.
- HOPWA prioritizes those in greatest need. HUD defines "housed" to include temporary situations unless there is a 14 day notice to vacate the premises, but HOPWA has an "other" category to also prioritize issues such as medical need.

9. SERVICE INTERVENTION RECOMMENDATIOS:

- Mr. Land introduced a table of ideas developed in a brainstorming session at PP&A's 9/22/2014 meeting for possible new or increased FY 2015 allocations in light of expected savings. Some ideas are ineligible for RW funds or are very broad.
- Mr. Pérez noted RW funding is $50.9 million with Part A and Minority AIDS Initiative (MAI) grants to the County, including $2.5 million in FY 25 MAI rollover, and the Part B grant via the state. Existing contracts were estimated at $44.2 million.
- RW FY 25 began 3/1/2015. Guidance has not been received, but at least one change is expected. The Substance Abuse and Mental Health Services Administration (SAMHSA) has required states, as part of their substance abuse block grants, to set aside 5% for HIV-specific programs. Counties usually are funded proportionate to their epidemic. Los Angeles typically received slightly over $3 million, but that will end 7/1/2015. DHSP will need to determine how to maintain the services.
- As noted above, DHSP was coordinating with HOPWA by using $6.1 million of the $44.2 million in contracted RW funds for more housing-related costs to maximize funds and free HOPWA resources for more housing specialists and vouchers. Services are Residential Care Facilities for the Chronically Ill, Transitional Care Facilities, Transitional and Emergency beds.
- Other anticipated costs include: biomedical interventions; Commission administrative costs; Quality Management activities; DHSP direct administration costs, e.g., a proposed Linkage to Care program anticipated to cost approximately $1 million. Such costs may vary, e.g., based on when biomedical intervention programs start and whether Commission costs decline.
- Services by Population: *Trans:* DHSP is developing an RFP that should be released by summer that will address both the Trans Wellness Center and Shelter/Drop-In Center recommendations depending on applicants' abilities to respond.
- *Native Americans:* The Red Circle Project is in place so gaps should be specified for further discussions with them.
- *HIV+ Unaware:* Consistent with the local epidemic, most unaware PLWH are gay men, largely people of color. The campaign recommendation lacks specificity for a very large market which already has seen multiple media campaigns, e.g., by the CDC, the Black AIDS Institute and various agencies. The impact of such campaigns remains unclear despite their expense.
- *PLWH Aged 50+:* California has a robust adult day care center system. Mr. Pérez was unaware of PLWH-specific centers, but they can access existing centers. The service is not HRSA-defined so would need to be defined including perceived need.
- Services for Potential Expansion: *Residential/Housing:* Many recommendations noted were already being addressed in coordination with HOPWA as discussed earlier. Mr. Fernandez noted HOPWA cannot provide Direct Emergency Financial Assistance (DEFA) to a client in subsidized housing. Consequently, clients may lose their housing in an emergency.
- *Medical Care Coordination (MCC):* Mr. Pérez reported MCC already has a large investment that was not yet maximized. Agencies were hiring for the last 18 months so expenditures are approaching allocations. Some smaller providers have part-

time MCC teams based on caseloads. Providers' rates reset based on meeting performance measures so incentives are in place and patient Viral Loads are decreasing. Benefits Specialty investment increased by 69% to better coordinate needs.

- *Substance Abuse/Addiction Medicine:* Changes/reviews were in progress at multiple bodies. e.g., California's review of Medi-Cal, expected completion by April; CSAT/CSAP resources, to be announced in July; and Substance Abuse Prevention and Control (SAPC), Department of Public Health, with a recent rate review which DHSP will discuss with them. DHSP supports integrated substance abuse/mental health, but felt increased allocations unwise in a changing environment with current allocations underutilized. DHSP felt localized services more effective so does not support a statewide program.
- *Benefits Support:* Benefits Specialists, as noted, have increased. Over half of ADAP enrollers report directly to ADAP.
- *Linkage to Care (LTC):* There are 25 general and research projects in place exploring how best to engage PLWH. Sophia Rumanes, MPH and her team have developed a separate proposal to mine surveillance data for outreach. More details are in the PowerPoint presented at the 2/17/2015 PP&A meeting, Linkage to, Re-engagement in and Retention in HIV Medical Care Overview. Covered California also has an outreach initiative to engage HIV- people in care.
- *Mental Health:* The recommendation to provide services without RW/County restrictions was too vague. RW will not fund scholarships or incentivize mental health professionals. DHSP is exploring the Department of Mental Health Full Service Partnership model for youth which provides multiple services for multiple morbidity youth.
- *Medical Outpatient/Specialty:* DHSP is working with the Office of AIDS to add pneumonia vaccine for the immunosuppressed to the formulary. It can be funded under the supplemental pharmacy line item. Prevention in primary care and Substance Brief Intervention Referral Treatment (SBIRT), supported by DHSP, are separate. Any prevention components added to the current menu of primary care components would first need to be defined and then discussed with providers. Biomedical interventions were being developed. The ADAP formulary now includes HCV treatment.
- *Legal:* DHSP has a contract with Public Counsel to address, e.g., housing discrimination. Any gaps need to be identified.
- New Services: *Optometry/Eyeglasses:* Optometry is an existing medical subspecialty provided through CHAIN. Dr. Green was unsure whether glasses were provided. Dr. Spencer reported her clinic sends patients to LensCrafters.
- *Peer Counselor/Navigator:* The Commission defunded peer-based services several years ago due to the lack of a consistent definition and quality measurements. Those issues would need to be addressed prior to refunding such services.
- *Outreach and Harm Reduction:* Some of the current programs were discussed under LTC
- System Strategies: *Centralized Intake:* Centralized intake would require a single data system to work effectively. Co-morbidity screening is already part of standards and incorporated by most providers.
- *Rapid Entry/Alternate Health Systems:* DHSP supports the concept, but has no authority or standing to direct it.
- *COLA Increases for Flat-Funded Programs:* Dr. Green reported agencies will be able to renegotiate and reapportion costs between direct and administrative costs within their budgets starting 3/1/2015 after DHSP receives final HRSA guidance.
- *Underlying Issues:* Issues such as poverty are too broad to address.

➲ Identify specific gaps in services for Native Americans to discuss with the Red Circle Project.
➲ Ms. Flynn will request a waiver from the DEFA eligibility requirement which prohibits it for those in subsidized housing.
➲ Agendize PP&A review of substance abuse including integration with mental health after DHSP's discussion with SAPC. That discussion will include SAPC's Community Assessment Service Centers which offer services for the general public.
➲ Determine if coordinator's line (Benefits Specialist warmline) was still warranted. It was in the Commission's 2013-2014 budget, but never actuated.
➲ If desired, peer navigators need to be defined to include trainings for qualified and accountable peer support activities. The Commission defunded the prior peer navigator category.
➲ Refer LTC structural barriers and "warm hand-off" to the Standards and Best Practices Committee.
➲ Agendize DHSP Optometry subspecialty report including glasses, HRSA regulations, provider resources and capacity.
➲ DHSP will estimate time needed to implement various proposals, e.g., 9-12 months, 18-24 months.

10. NEXT STEPS:

A. Task/Assignment Recap: There was no additional discussion.

B. Agenda Development for Next Meeting: ➲ Messrs. Land and Ballesteros will coordinate upcoming agendas with DHSP.

11. ANNOUNCEMENTS: There were no announcements.

12. ADJOURNMENT: The meeting adjourned at 4:00 pm.